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Drawing in not Encouraging Away: Systemic Team Formulation to Support the Trauma- Informed Care of a Lady with Intellectual Disability, in the Context of COVID-19

All names and some personal details have been changed in order to preserve confidentiality. The 'client' (care team) used in the case study gave their consent for the sessions to be written up.

Abstract

Purpose: The Purpose of this paper is to present a case study using a systemic team formulation approach, in the context of supporting a woman with intellectual disabilities with a history of trauma.

Design/Methodology/Approach: A reflective stance is used to describe the process of assessment, hypothesising, formulation and intervention in a single case study design.

Findings: Feedback from care staff suggests that they found a team formulation approach helps to improve their understanding of the service user they support.

Implications: The paper discusses how systemic team formulation can draw on trauma-informed care principles in the context of supporting an individual with an intellectual disability. Future research should aim to replicate the approach in order for findings to be applied more broadly. COVID-19 has meant clinical working has had to be adapted, clinicians should carefully consider how collaborative and meaningful work can continue to be facilitated within the current parameters.

Originality: This case study contributes to the literature in the use of systemic team formulation interventions within an intellectual disability context, drawing on trauma-informed care principles and reflecting on adapted working within the COVID-19 pandemic.

Keywords: Intellectual disabilities, systemic, team formulation, trauma-informed care, COVID-19.

Review of the Literature

Systemic theory views difficulties and distress within the context of relationships. Problems and their solutions are thought about in terms of system structure and patterns of behaviour (Dallos & Draper, 2015). Unlike many individual therapy approaches that focus on symptom reduction (first order change), systemic therapy aims to make changes to systems, relationships and patterns of interactions (second order change) (Davey et al., 2012).

Psychological formulation is defined as the process of developing an understanding or hypotheses about difficulties, rooted in psychological theory (Johnstone & Dallos, 2014). Within systemic work, the process of formulating can in itself bring about important change. Change theories within systemic formulation can be drawn from Milan and Post-Milan theory; hypothesising, circularity and neutrality (Brown, 2010; Cecchin, 1987; Rambo et al., 2012). By asking certain questions that get people within the system thinking about beliefs, relational patterns and meanings, systemic shifts can take place (Johnstone & Dallos, 2014).

For People with Intellectual Disabilities (PWID), there is often a large number of people within an individual's 'network'. This may include paid care staff, family, and professionals. Taking an Ecological Systems Theory perspective, we are all influenced by the context around us (Bronfenbrenner, 1992). For PWID, who are likely to have larger networks, a systemic approach is particularly fitting (Baum, Lynggaard, & Andersen, 2018; Haydon-Laurelut, Bissmire, & Hall, 2009).

Working systemically with the networks of PWID, though under documented, is becoming increasingly encouraged (Baum et al., 2018). Best practice guidance highlights the value of working relationally and systemically with the networks and teams surrounding individuals with an intellectual disability (ID) and the adaption of psychological interventions to best meet the preferences, understanding and needs of each individual (National Institute for Health and Care Excellence, 2016; The British Psychological Society, 2018). Johnson and Viljoen (2017) discuss that like many other interventions used in ID settings (e.g. Positive Behavioural Support (PBS) and

Applied Behavioural Analysis (APA)), working with a system is important in facilitating change. An evaluation of carers experiences of systemic working within a Community Intellectual Disability Team (CIDT), found that most carers thought systemic sessions were helpful and enabled them to expand their views (Smyly et al., 2008). Systemic team formulation can hold multiple purposes, but is often used to support systems to build a shared understanding of difficulties, hold multiple perspectives in mind and allowing space for considering the service user-team relationship (Geach et al., 2019; Johnstone & Dallos, 2014).

Within health services there is an increasing focus on the recognition of trauma in the peoples' lives (Reeves, 2015). The impacts of trauma can be widespread and long lasting and the literature suggests that people with disabilities are at increased risk of exposure to stressful and traumatic life experiences (Hughes et al., 2012). It is also known that health services can be distressing and re-traumatising (Kimberg & Wheeler, 2019). It is therefore important that services adapt their service delivery in line with these needs. Trauma-informed care is an approach to service delivery rooted in understanding trauma, shifting people from asking 'what is wrong with you?' to considering 'what has happened to you?'. In order to deliver trauma-informed care, relationships need to be based on trust, connection and safety (Kimberg & Wheeler, 2019; Sweeney et al., 2018). Despite PWID experiencing disproportionately more exposure to trauma, the evidence-base around the treatment and support of trauma in PWID is sparse. A study exploring health professionals experiences of working with PWID who have experienced trauma, highlights the importance of trauma-informed care within healthcare services; particularly considering how a trauma lens could inform the understanding of clinical presentations and limit diagnostic overshadow (Truesdale et al., 2019).

This paper aims to take a reflective stance to explore the use of systemic team formulation, in the context of supporting a woman with ID, considering trauma-informed care and adapted working within the COVID-19 pandemic.

Referral

Jane (pseudonym) was referred internally to Psychology within the Community Intellectual Disability Team (CIDT). Jane's care team had concerns that she had been presenting with a lack of motivation and engagement for a number of years. They felt Jane was not reaching her potential and described her as 'self-disabling'. They were subsequently hoping for a review of her care hours with social care. The care team reported feeling stuck and frustrated.

Context

Jane is a woman in her 50s with an intellectual disability. The care team currently supporting her have done so for around 10 years. The work was undertaken by a trainee clinical psychologist and a clinical psychologist working in ID services.

Assessment, Hypothesising and Formulation

The first stage of the assessment was an in-depth review of Jane's clinical care records; a timeline of significant events was drafted, and initial hypotheses were discussed in supervision.

Jane's care team felt that involving Jane in the assessment process was not in her best interest as it may cause her unnecessary distress. The clinical psychologist had previously met Jane, prior to COVID-19 restrictions, and ascertained that she was happy for us to work with her team. The same psychologist had undertaken an initial face to face session with the manager of the service to hear about Jane's history and about his concerns, both for Jane and for the team who support her. It was therefore agreed that the focus of the work should be with Jane's network, to help them formulate and plan an approach to her care that was trauma informed.

Preliminary Hypotheses

From reviewing Jane's notes and from initial conversations with the care team, it was clear that trauma and loss held a significant role in Jane's life. Jane's mental health and abilities to cope independently had deteriorated in line with a number of traumatic experiences. It can be

hypothesised that trauma has impacted the way Jane sees herself, others and the world around her, significantly impacting her sense of self and relationships with others.

Power appeared as a theme; with multiple incidents where power was taken away from Jane and life changing decisions were made for her. We wondered what message this gave Jane about her power and her abilities to make decisions and to hold a sense of autonomy and self-esteem.

Relationships appear to have been complex and difficult for Jane and she has experienced a number of losses. Many of the significant relationships in Jane's life are with people who have a 'carer' role. We were curious about what this meant for how Jane views relationships and how to get closeness and connection with others.

The care team expressed frustration and reported feelings of burnout in relation to Jane not meeting her potential and presenting as 'self-disabling'. We considered what the care team felt this meant about them as carers. Most people who go into care roles do so because they want to support people to live as independently and as well as possible. We reflected on how it may feel for staff to support someone where this value had not felt possible.

We were curious about the function of avoiding demands and 'self-disablement' within the system. Was it that when Jane had done well in the past and been 'meeting her potential' she had lost people? Many of the traumas in Jane's life happened when she was living more independently and 'doing well'; we wondered what message this may have given Jane. Perhaps doing well was dangerous as it might lead to loss, perhaps care and connection only comes when you present as struggling?

Further Assessment and Hypothesis Testing

To further assess, a staff consultation session was convened with Jane's care team. A tentative formulation of initial hypotheses was shared with the team. We thought together about

Jane's history of trauma and how this may have shaped the way Jane thinks about herself and the world now. We thought about the care team's interactions with Jane and some of the common behavioural patterns. Holding a position of curiosity and neutrality (Cecchin, 1987), we aimed to elicit a collaborative discussion in order to test our hypotheses and co-construct a working formulation.

Context: Working Clinically during COVID- 19

It is important to highlight the context of the consultation process here; at the time of the consultation the COVID-19 pandemic was having a huge effect on how NHS services were run. Following best practice guidance, as a CIDT we were facilitating all non-urgent appointments via video appointments (British Psychological Society & Division of Clinical Psychology, 2020). If unable to join meetings from individual devices, care teams were joining as a group, socially distanced in a room together, while wearing Personal Protective Equipment (PPE).

The combination of the care team wearing PPE and having to socially distance on one camera, meant communication between us was difficult. We were unable to hear clearly what the staff team were saying, and we were unable to see their expressions and responses to discussions. This made it very difficult to collaboratively test our hypotheses and build a formulation together.

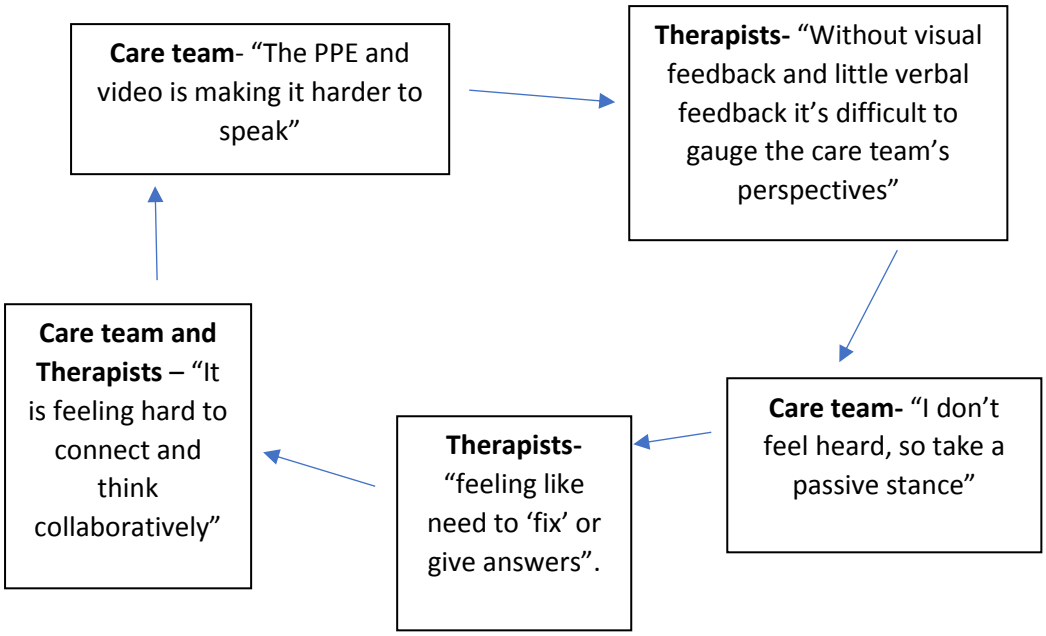
This experience made us think about power and difference; as therapists we were able to access the video call from our own devices from separate locations, without PPE masks, making it easier for us to communicate. This difference perhaps positioned us in a place of privilege. As therapists you can sometimes feel positioned as the 'expert' who gives solutions as opposed to working with a system. Health service structure can also give a systemic message of hierarchy, through professional positions and pay banding. We noticed we were perhaps being pulled into a position of 'fixing', rather than working alongside the team. Perhaps the explicit 'difference' we were experiencing in this context meant we were noticing systemic power differentials more visibly. It

may be that this dynamic played out through our position as 'curious facilitators' feeling harder to maintain (see figure1).

We hypothesised about this experience with the care team and later in supervision. We also thought about how a key theme emerging from the initial hypotheses regarding Jane's network was about 'connection' and how Jane could get the connection she needs. We reflected that we felt 'un-connected' as a facilitator- care team system in this session and how this posed another barrier to considering connection more broadly.

Figure 1.

Communication pattern between therapist and staff team; video consultation.



Preliminary Formulation

Despite the challenges that arose from the video consultation we were able to collect further information from the care team during the session, enabling us to develop a tentative systemic formulation. We used Johnstone & Dallos (2014) systemic formulation framework.

Deconstructing the Problem

The staff team described much of the 'problem' as Jane not meeting her potential and 'disabling herself'; this presented as Jane not engaging with activities and tasks, showing little motivation, soiling, self-harming and avoiding demands.

The care team felt that this was a problem for Jane as she was not living her life to her full potential which may impact upon her wellbeing and life satisfaction. For the care team this presented as a problem as they felt unable to do their job in line with their values, leaving them feeling frustrated.

Pattern of Behaviour and Feedback loops

Using the information gathered and our initial hypotheses, it was considered that the following patterns of behaviour between Jane and the staff team may have a role in the maintenance of the problems.

Figure 2 highlights the staff team's experience of Jane not engaging with tasks and activities, leaving staff feeling frustrated and helpless. Staff interpret this behaviour as Jane not reaching her potential and disabling herself. Staff may respond by taking control and doing everything for Jane. From Jane's life experiences and history of trauma it is hypothesised that she may hold herself in low self-esteem and lack confidence in her abilities, leaving her feeling low and unmotivated. Consequently, Jane is unlikely to engage with things independently and may seek out help as she does not believe she is capable. Also thinking about Jane's life experiences of power, she has often been in a position of disempowerment, with others doing things for or to her. Jane may hold a narrative that she is powerless and therefore there is no point in trying to do things independently. The cycle between Jane and her care team may contribute to inadvertently reinforcing Jane's belief that she is unable to do things herself, that she needs others to do things for her, meaning her self-esteem remains low.

Figure 2.

Staff and Jane feeling stuck in a cycle of disengagement.

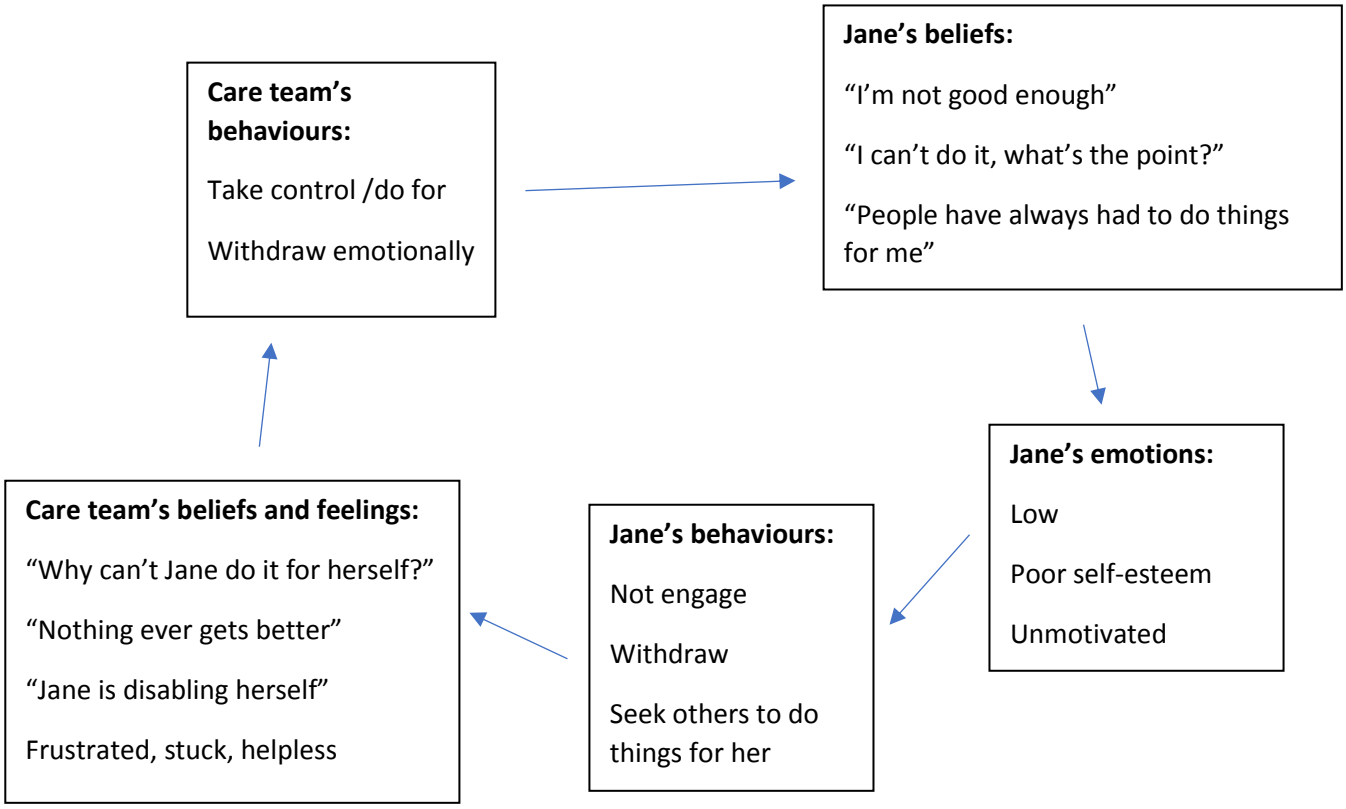
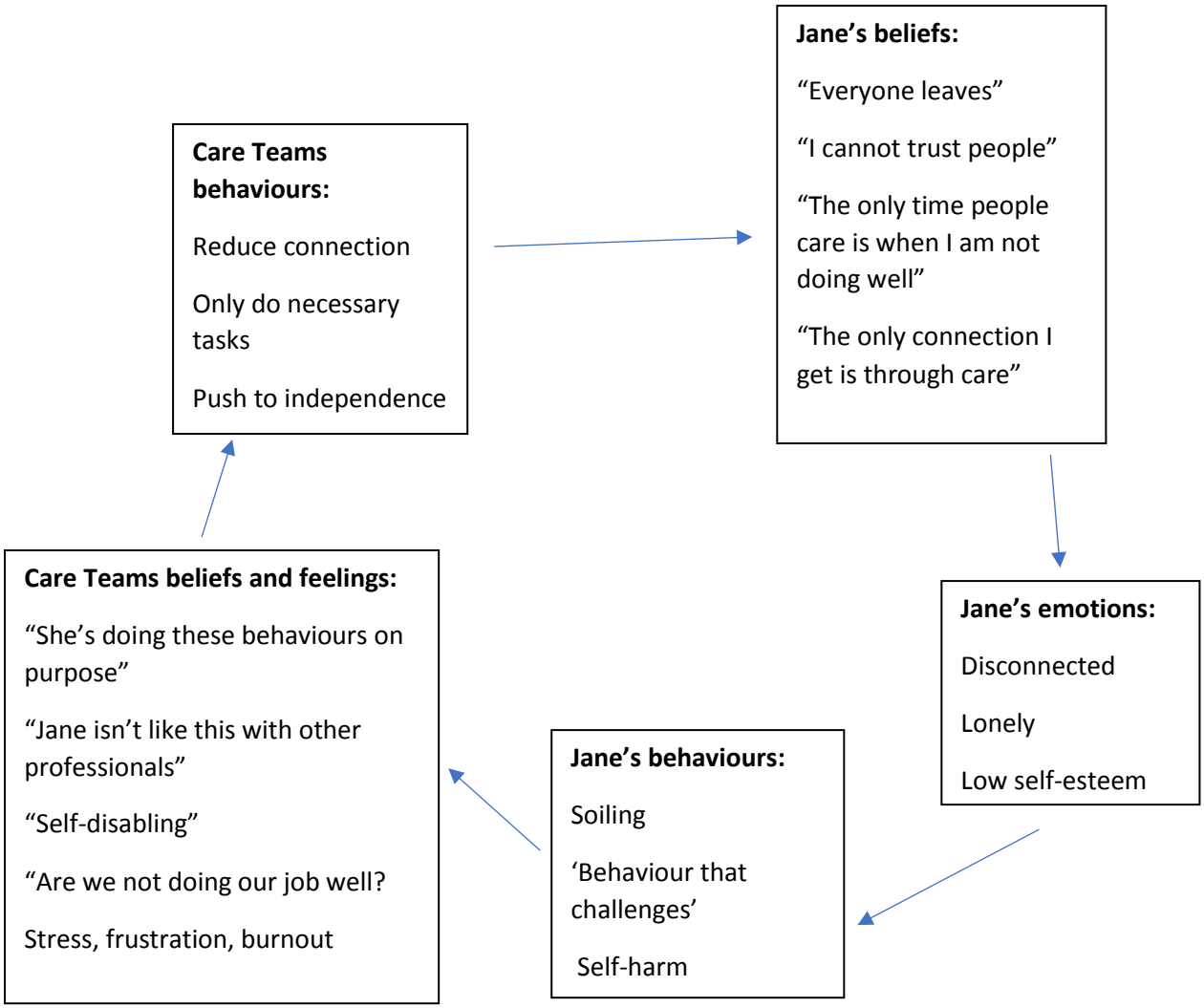


Figure 3 maps how Jane may have learnt over her lifetime that when she does 'well' and is showing independence people pull away. An example of this may be when she had a period, historically, as an inpatient in hospital. When Jane was doing 'well', care reduced, and she would be encouraged to move back into the community to live independently. This may give Jane the message that the only way to gain care and connection is through showing what her staff team describe as 'self-disabling' behaviours or behaviours that challenge. Not reaching her potential may be a way of Jane communicating that she wants connection with staff. As one of Jane's main sources of connection and interaction is from staff, it is understandable that Jane wants to draw staff closer to her as this can help her to feel safe.

Inadvertently, these behaviours give the staff team the message that Jane is doing things intentionally as she can present more able around other professionals. This leaves the care team frustrated and doubting their abilities to effectively support Jane. This experience goes against the team's core values of 'enabling' those they support. These feelings mean the care team are inclined to withdraw their emotional connection. While this acts as a means of staff trying to protect themselves, this inadvertently gives Jane the message that people do not care about her and she is alone.

Figure 3.

Cycle of loss of connection between Jane and the staff team.



Exceptions/ Strengths

Interestingly, carrying out the consultation during the COVID-19 pandemic allowed for the exploration of exceptions. When the UK went into 'lockdown', most supported living services created 'bubbles' within their services to protect vulnerable service users and provided more inhouse activities. Jane's team reflected that Jane adapted well to the lockdown and it appeared that this way of life was more suited to her. It was hypothesised that with more time spent at home with key staff, fewer external demands and less pressure to 'reach her potential', Jane was able to feel more comfortable and safe. There may also have been more opportunity for one-to-one support with more staff around and a smaller core staff team forming a 'bubble' within services. This exception gives weight to our hypothesis that considered the possibility that Jane is seeking more emotional connection to her staff team and that she considers independence and doing well as a threat, as this may mean she is pushed away and left with even less connection. Jane may not currently have the sense of self-esteem and self-belief that means she feels confident enough to engage the demands that were placed on her 'pre-lockdown'.

Contextual Factors

Jane has lived her life with multiple traumas, losses and some evidence of separations; research suggests that such experiences can hugely impact attachment, the ability to form and maintain trusting relationships (Barazzone et al., 2019; Courtois, 2004; Sweeney et al., 2018).

Social GGRRAAACCEEESSS (SG) is a mnemonic standing for gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation, and spirituality (Burnham et al., 2008). Considering SG can support the exploration of context, supporting the system to build an awareness of potential areas of difference, power and intersection (Burnham, 2012). In terms of Jane's SG, Jane has an ID and has experienced severe mental health difficulties. Historically, PWID and/or mental health difficulties have not been treated equally, being stigmatised and disempowered. While this has improved somewhat since the

normalization movement when the rights and independence of PWID became more recognised (Wolfenberger & Bengt, 1972), systemic disempowerment is evident. It is important to consider the intersectionality of gender, disability and mental health and how this could have added to the discrimination in Jane's life (Crenshaw, 2017; Thakur, 2020). For Jane, this intersectionality may have meant she has been exposed to even greater levels of stigma and inequality, making issues of power crucial to the way the system understands the current presenting difficulties.

It is also important to think about our SGs as Jane's system, as therapists and a care team, and how these may be similar or different. Our context and experiences shape the way we work, think and understand. In terms of Jane's care team, she has been supported by the same service for 10-years and carers have remained mostly constant. Jane is mainly supported by females of a range of ages. It was interesting to see how those that were closer in age to Jane and had experienced how services may have been for Jane 10-20 years ago used this similarity to better understand Jane's experience (Pote, 2018). As therapists we were both female, white, and younger than Jane. We shared similar ethnicity, class, geography, and gender to Jane, however we do not have an intellectual disability and have not experienced some of the systemic discrimination that Jane has. While we can relate to some of the power issues Jane may have experienced, being female. Other SGs such as ability and education place us in a position of privilege. We were conscious that society and services can often privilege higher ability, meaning PWID can be left out of conversations. We reflected on wanting to challenge this discourse, while having to work in a way that did exclude Jane from being physically present due to a best interest decision around her understanding of the process and managing the distress it may have caused her. Throughout the consultation process we sought to use questions that elicited Jane's voice and perspectives, such as 'what would Jane's perspective be?', 'what would Jane want to be different'? We hoped that this could keep us grounded to Jane's voice, challenging the dominant discourse, while acknowledging the issues of power and difference that presented.

In relation to the care team, we varied in ages, but shared the same ethnicity and gender. We had both previously worked as support workers with PWID and found that this helped us to feel aligned with the perspectives of the team. One of the reasons that the initial video consultation may have felt so challenging for us was because this privileged the voice of the care team's management and ours as therapists and silenced the voices of the care team who work with Jane. It therefore felt important to give the care team the opportunity to be heard and included. While we shared similarities with the care team, we also recognised that as a trainee psychologist and clinical psychologist we now held different positions. This may leave us with certain 'blind spots' and bias and we should be careful not to make assumptions about how the care team may view the situation.

Beliefs within the System

A number of beliefs and explanations were held by members of Jane's system. Key narratives about Jane are summarised below.

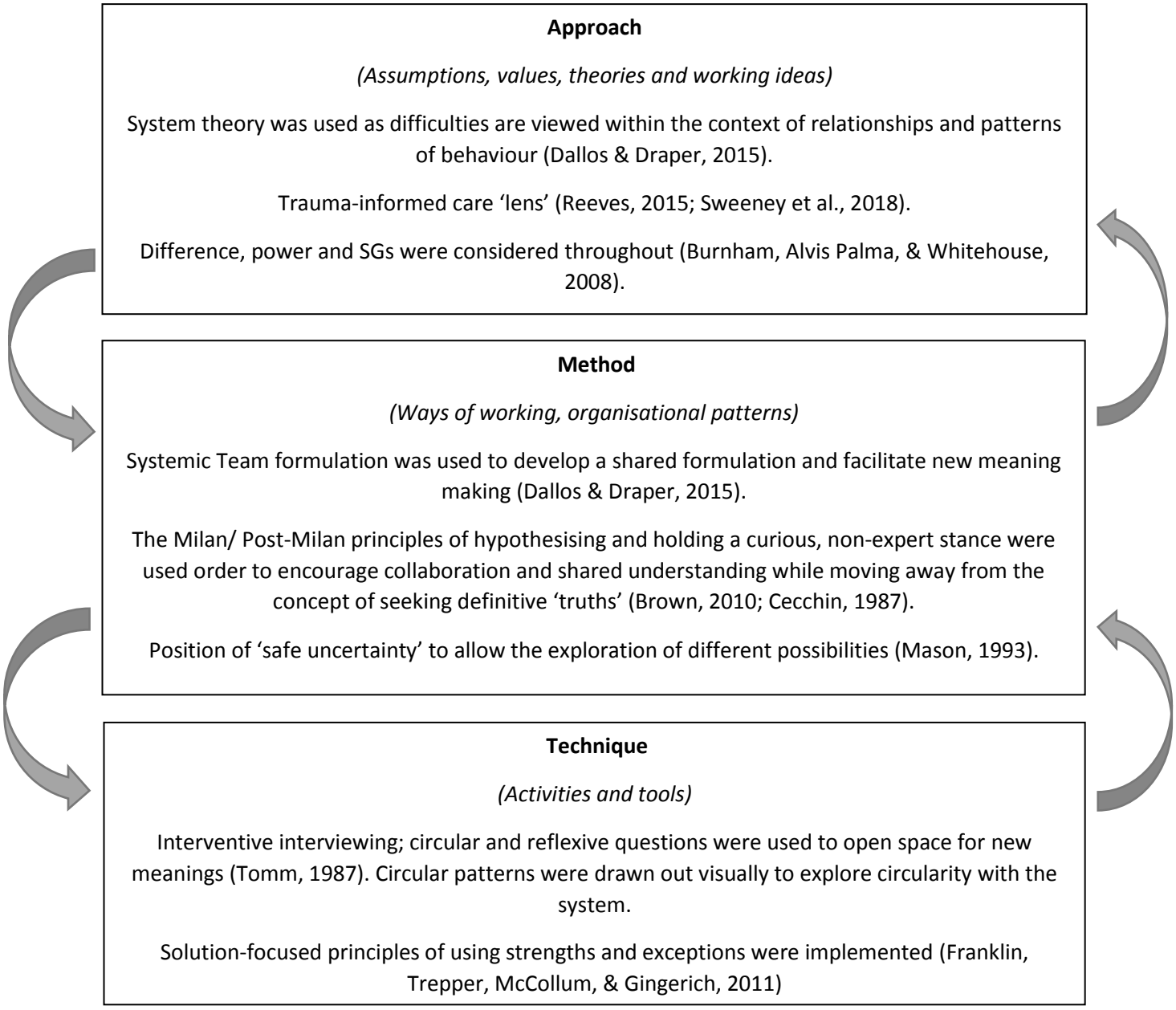
- "Jane 'disables herself' on purpose".
- "Jane is much more able around other professionals".
- "As a staff team we are not helping Jane".

Intervention

Due to a best interest decision, direct work with Jane was not indicated, meaning working with Jane's care team was felt to be the most helpful route to support the system. The presenting difficulties appeared to be relational in nature, therefore a systemic team formulation was agreed as the most appropriate intervention. Figure 4 gives the rationale for the intervention based on Burnham's (1992) Approach, Method, Technique framework.

Figure 4.

Approach, Method, Technique used for our systemic team formulation (Burnham, 1992).



Implementation

The systemic team formulation was held face-to-face, allowing for a more collaborative session given the challenges that had presented in the initial video consultation. Due to restrictions as a result of COVID-19, clinic rooms had limited capacity to allow for social distancing and all attendees were required to wear PPE. Four of the care team attended with two therapists as facilitators.

Hopes and goals were explored as well as a rationale for systemic team formulation. We discussed positioning and the care team's role as experts of their experiences of working with Jane and our role as facilitators of systemic theory and formulation. The care team hoped to gain new understandings and ways of supporting Jane. Together we thought about trauma, Jane's history and what this might mean about how Jane sees herself, others, and the world. We considered what trauma-informed care would look like in practice (Sweeney et al., 2018). Considering circularity in relationships, we mapped recent incidents between the staff team and Jane. Using these examples, we applied a trauma-informed 'lens' to inform alternative possibilities about Jane and the care team's responses and behaviours.

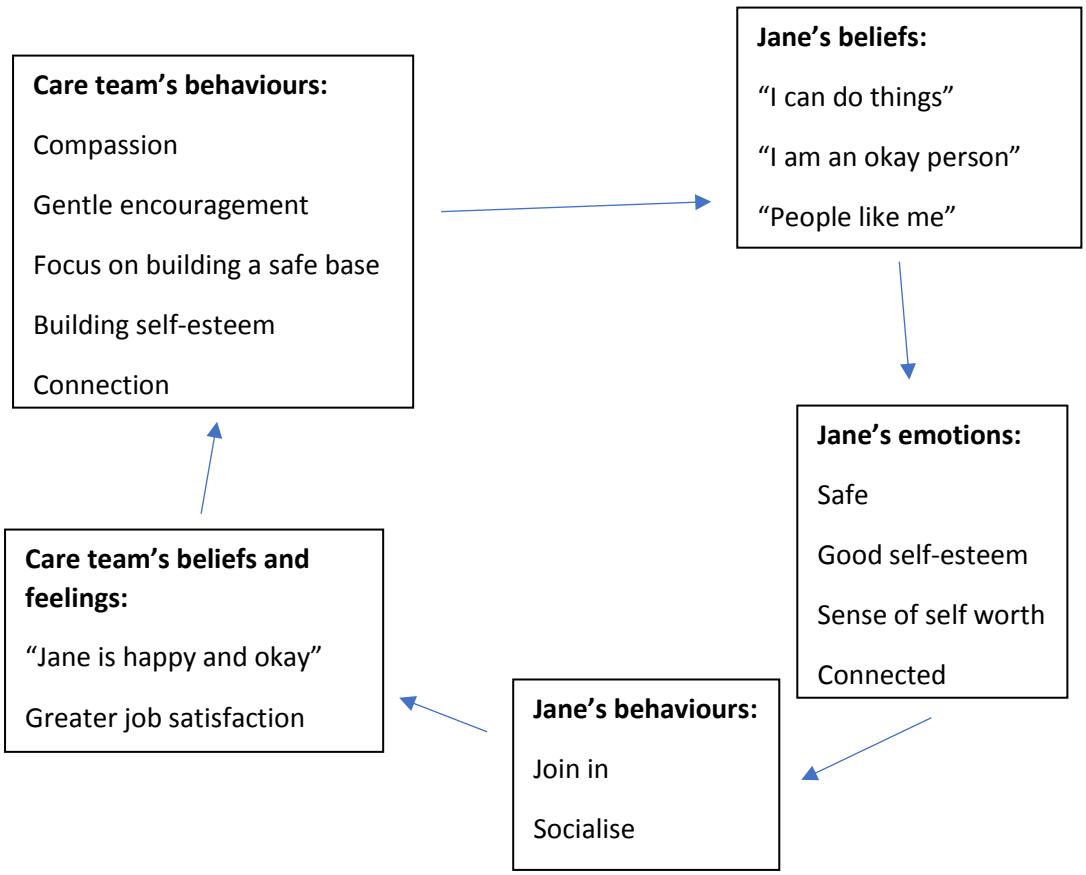
We discussed the care team's strengths and values and how this could be understood in relation to the difficulties within the system. It became clear that the care team's values of enabling independence, while coming from a place of great compassion, may not be the focus that best fitted with Jane's experiences and preferences. Using the team's strengths, we considered how they could use this compassion to shift toward drawing Jane 'in' to feel safe and connected, as opposed to encouraging Jane 'away' through pressure for greater independence.

Using a combination of trauma-informed care and a shift to thinking in a circular way, the care team began to describe themselves within the patterns of behaviours as opposed to bystanders to the 'problem' and we noticed a shift away from viewing the problem as located within Jane or within the staff team themselves.

The outcome of the session focused on how the care team could use these alternative narratives to support Jane in the future. By understanding Jane through a trauma-informed 'lens' and building Jane's sense of safety and self-esteem she may be better able to work towards exploring more independence and 'reaching her potential'. See figure 5 for an alternative feedback-loop.

Figure 5.

Alternative feedback loop.



Evaluation

At the end of the session, we gained verbal feedback. Staff said they found the session helpful overall. One member of the team expressed that having the patterns of behaviours and interactions mapped out in feedback loops "helped me to understand what is happening better". Another commented that "the complexity and messiness helped us to see what it might be like for

Jane, in her mind". The team commented that it was helpful for them to have protected time and it was important that they had practical tools and ideas to take away at the end the session.

Discussion

This case report presents the use of a systemic approach with a team, in the context of ID, trauma and clinical working in the COVID-19 pandemic. Taking a reflective stance, the process of the initial assessment, hypothesising, preliminary formulation and intervention through systemic formulation with a care team are reported. Verbal feedback from the care team suggests that they found the systemic formulation helpful to better understand Jane. It was clear from observing the staff's conversations that there was a shift towards the team seeing themselves within the system, as opposed to the 'problem' being located in Jane.

The outcomes are in line with current research. Baum, Lynggaard and Andersen (2018), highlight the value of working with teams within an ID context, expressing how bringing together multiple perspectives and expertise can lead to the creation of new stories and meanings. These new meanings can elicit new actions and shifts in 'stuck' patterns. The theory of change in team formulation is the space to 'perturb' beliefs, behavioural patterns and narratives (Johnstone & Dallos, 2014). The feedback in the current study fits with previous research in the field; team formulation in a forensic ID service was found to be a helpful experience for staff, supporting them to develop more empathy towards service-users and build their psychological understanding of presenting difficulties (Whitton et al., 2016). More broadly, the findings echo benefits that have been identified from systemic team formulation across other populations; including increased empathy and reflexivity, improve morale, support culture shift within teams and improve consistency (Geach et al., 2019; Hollingworth & Johnstone, 2014; Johnstone & Dallos, 2014).

A trauma-informed framework felt particularly fitting for Jane's system. By holding a trauma-informed 'lens' those supporting trauma survivors can better understand behaviours that may be 'coping adaptions', as well as stay vigilant to possible power issues where 'helping' can sometimes

inadvertently lead to helplessness and disempowerment. By holding in mind trauma, relationships can be built on connection, safety and trust (Kimberg & Wheeler, 2019; Sweeney et al., 2018). Through the shift in focus to understand Jane's experience through the lens of trauma, the care team appeared to be able to form alternative explanations and solutions. This study builds on emerging research considering the importance of developing trauma-informed services and initiatives for PWID (Keesler, 2020; Truesdale et al., 2019).

Dallos and Johnstone (2014) discuss the value of drawing on a range of models in an integrative approach within team formulation in order to build a meaningful picture of often complex systems. Using systemic theory alongside models of trauma-informed care enabled this case report to present an integrative approach to working with a complex case.

The COVID-19 pandemic has caused challenges to delivering psychological services (Békés & Doorn, 2020; McBeath et al., 2020). In this case, delivering a collaborative and meaningful team formulations session via video call was problematic. In a study comparing therapeutic groups delivered in person and via video call, it was found that while connection to the facilitator was equal in both groups, group cohesion was rated as significantly lower in the group facilitated via video (Lopez et al., 2020). The current context has shone a light on the need for reflexivity and flexibility to respond to challenges. As expressed in Baum et al., (2018) for systemic work to be helpful and meaningful, it is not about having a "big enough room" or the best resources, but about the commitment of the system in making the work possible within the parameters of the situation. It is hoped that learning from the current challenges to services will be captured and used to inform future practice. See Appendix 1 for further reflections.

Limitations

Although brief verbal feedback was sought, no standardised outcome measure was used. A measure such as the SCORE-15 may be useful to better understand progress (Stratton et al., 2010). Although this measure is designed for families and couples it may be suitable to adapt for teams. In

addition, only a small proportion of the care team were able to attend the formulation sessions, if further sessions were able to be offered, perhaps more robust conclusions may have been ascertained. A follow- up appointment with the care team would also have allowed for the exploration of longer-term impacts. Despite the considerations and challenges of not being able to involve Jane directly in the work, it would be interesting to hear Jane's perspective on the impact of this work on her and her staff team. While case studies can give valuable contributions to the literature, because they are single-case design they are unable to be generalised.

Implications for Practice and Future Research

This paper begins to explore the use of embedding trauma-informed care within systemic team formulation when working with a complex case. Although findings must be held tentatively, it appears that through opening up conversations about trauma, shifting narratives and exploring new hypotheses, alternative stories and solutions can be co-created. Initial reflections from the care team suggested that they valued this approach. However, findings need to be tested further and this approach needs to be replicated within more ID settings. There is growing interest in this area and future research exploring the use of trauma-informed care within systemic team formulation, in the ID population, would add great value to the field. Challenges to delivering psychological services during the COVID-19 pandemic are evident, clinicians and services should consider carefully how systemic team formulations sessions are facilitated when working remotely; considering the importance of each team member being able to voice their perspectives comfortably and safely. Future research exploring the learning from this time should aim to give guidance to best practice.

Conclusion

Using a reflective stance, this case report explores the use of systemic team formulation with the care team of a lady with ID, trauma-informed care principles are used as a 'lens' within the formulation. From initial feedback from a small number of the care team, the approach appears to be helpful in developing alternative understandings. The approach needs to be replicated further in

order for findings to be applied more broadly. Working within the COVID-19 pandemic has meant adaptations have had to be made. Clinicians must carefully consider how collaborative and meaningful work can continue to be facilitated within the current parameters.

Appendix 1: Reflections

At times, it felt as though we were at risk of losing Jane's voice and perspectives because of working in such a way that meant Jane's care team were the 'client'. Baum, Lynggaard, and Andersen (2018) discuss how as therapists in the context of ID, we are driven by the value of inclusion and guided by the context of the policy we work within. This can leave us with dilemmas regarding power when the PWID may not be being fully included, in this case because of a best interest decision. In supervision we wondered how we could still hold Jane's voice at the centre of the work. One consideration was, in 'pre-COVID-19' working, with no limits on room capacity, we would have liked to invite a reflecting team to the session. Reflecting teams allow for the consideration of multiple and new perspectives (Wulff & St. George, 2017). One technique known as 'listening as if' may have been helpful for this work, meaning a member of the reflecting team could have held the position of Jane. This would have allowed us as therapists to feel anchored in holding Jane's voice, while also having the space to explore other ideas and avenues of thought. In the absence of this opportunity, the authors sought to hold a reflective stance throughout the session, offering alternative perspectives at regular intervals.

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